Division of Professions and Occupations
Office of Licensing—Dental
1560 Broadway, Suite 1350
Denver, CO 80202
(303) 894-7800 / Fax (303) 869-7693
www.dora.colorado.gov/professions

Application for Approval to Administer
LOCAL ANESTHESIA—DENTAL HYGIENIST
Fee: $35
Fees may be paid by a check or money order drawn in U.S. dollars on a U.S. bank and made payable to State of Colorado.

APPLICANT INSTRUCTIONS

Local Anesthesia Privileges Required. Board Rule XIV requires that a dental hygienist be actively licensed and privileged in order to administer local anesthesia or a local anesthesia reversal agent, under indirect supervision of a dentist, in the state of Colorado. It is illegal for a Colorado licensed dental hygienist to administer local anesthesia prior to documenting compliance with Rule XIV and receiving approval from the Board.

Basic Requirements. All applicants must hold an active Colorado dental hygienist license. Other requirements are outlined in the Dental Practice Law of Colorado and Board Rule XIV. Both are available online at www.dora.colorado.gov/professions/dentalhygienists.

- Local anesthesia privileges will be issued once and will remain valid as long as the licensee maintains an active license to practice dental hygiene in Colorado. If you **do not** intend to administer local anesthesia, you **do not** need to complete this application.
- All Colorado-licensed dental hygienists **shall** be authorized to administer nitrous oxide/oxygen inhalation analgesia with the proper training and certification.

About the Application. This application is to be completed by you and returned to the Office of Licensing. All questions on the application are mandatory, and all supporting documents must be received before the application may be considered. The application forms must be completed in original ink or typed. Keep a copy of the completed application and supporting documents for your records.

Application Expiration. Your application will be kept on file for one (1) year from the date of receipt in the Division. Your file and all supporting documentation will be purged if you do not submit required documents and complete your application process in one year. You will need to submit a new application packet after that time.

Social Security Number is Required. Effective January 1, 2009, a Social Security Number is required for all licensees. The Division will consider an application to be incomplete when the applicant fails to submit their Social Security Number. Exceptions are made for foreign nationals not physically present in the United States and for non-immigrants in the United States on student visas who do not have a Social Security Number. These applicants must submit a signed Social Security Number Affidavit in lieu of a Social Security Number. You may call (303) 894-7800 to request that one be mailed to you.

Disclosure of Addresses. Consistent with Colorado law, all addresses and phone numbers on record with the Division are public record and must be provided to the public when requested. It is your responsibility to keep your contact information current in our system. **Your email address is not open to public record, but must be provided in this application.** Any requests for additional information, license information and renewal notices will be emailed to the email address on record. If your email address is not current, it is possible you will not receive important information from the Division. You can change your contact information online by using Online Services at www.dora.colorado.gov/professions/onlineservices.

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APPLICANT CHECKLIST

To apply for **approval (privilege) to administer local anesthesia:**

- ☐ **Complete the attached application.** Return the completed application and all supporting documentation to the Office of Licensing.
- ☐ **Provide documentation of any name change.** If your name has changed since you obtained a previously-issued license, or if your name is different on any of your supporting documentation, you must provide a copy of the legal document verifying the name change (i.e., marriage license, divorce decree, or court order).
- ☐ **Submit proof of current Basic Life Support (BLS) certification.**
- ☐ **Include documentation of your education/training** using the Completion of Training Verification form attached.

Return your completed application packet and all supporting documentation to:

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The content of this application must not be changed. If the content is changed, the applicant may be referred to the Colorado State Attorney General's Office for violation of Colorado law.

Colorado Dental Hygienist License Number: _____ **Expiration Date:** _____

PART 1—APPLICANT INFORMATION

Name: First:	Middle:	Last:	Suffix:
Previous Name(s):			
Social Security Number: *			
E-mail Address: ***(This will be the primary communication method)***			
Mailing Address: *This is a ☐ Home ☐ Business*	PO Box, Street: City, State, Zip:		
Daytime Telephone Number: ( )		**Date of Birth** (mm/dd/yyyy)**:**	
Place of Birth (city and state, or foreign country)**:**		**Gender:** ☐ *Male* ☐ *Female*	

PART 2—BASIC LIFE SUPPORT CERTIFICATION

List below and submit proof of current Basic Life Support (BLS) certification.

BLS certification issue or renewal date: _____ **Expiration date**: _____

* **Social Security Number Disclosure:** Section 24-34-107(1) of the Colorado Revised Statutes requires that every application by an individual for a license issued pursuant to the authority set forth in title 12, C.R.S., by the Department of Regulatory Agencies, shall require the applicant's social security number. Disclosure of your social security number is mandatory for purposes of establishing, modifying, or enforcing child support under § 14-14-113 and § 26-13-126, C.R.S.; locating an individual who is under an obligation to pay child support as required by § 26-13-107(3)(a)(I)(A), C.R.S.; and reporting to the Health Integrity and Protection Data Bank as required by 45 CFR §§ 61.1 et seq. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Disclosure of your social security number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation for identification purposes only. Your social security number will not be released for any other purpose not provided for by law.

OFFICE USE ONLY **DATE APPROVED:** _____ **DATE ISSUED:** _____

APPLICANT NAME: _____

PART 3—SCREENING QUESTIONS

Provide the following for each YES response to screening questions 1, 2, and 3:

- A personally written explanation;
- A copy of the formal complaint/pleading;
- The answer to the complaint for malpractice issues;
- A copy of the final outcome(s) and/or a report of status if judgment is pending;
- Proof of compliance if under criminal probation;
- A copy of investigative report/complaint; and
- Any further information requested by the Board in a separate communication.

1. Has your license to practice dental hygiene ever been suspended, revoked, or otherwise disciplined in any state or territory of the United States, or in any foreign country related to an anesthesia/analgesia incident? ☐ YES ☐ NO

2. Have you ever had **any** malpractice judgment, malpractice settlement, or governmental/private agency disciplinary action against you or is such an action currently pending against you? ☐ YES ☐ NO

3. Have you ever had any criminal conviction, deferred judgment or plea of *nolo contendere* entered against you or is there any criminal charge or investigation currently pending against you? This includes, but is not limited to, any judgments/charges related to sales, distribution, possession, manufacture or dispensation of any controlled or illegal substance. ☐ YES ☐ NO

Provide the following for each YES response to screening questions 4 through 6:

- A personally written explanation.

For questions 4 or 5, also give:

- Dates of onset;
- Description of treatment;
- Name and address of treating physician; and
- Your description of the current status of your condition. You may wish to submit a physician's report of the current status of your condition and any limitations which may affect your ability to safely practice dental hygiene.

4. Do you now abuse or excessively use, or have you in the last five years abused or excessively used, any habit forming drug, including alcohol, or any controlled substance that has a) resulted in any accusation or discipline for misconduct, unreliability, neglect of work, or failure to meet professional responsibilities; or b) affected your ability to practice as a dental hygienist safely and competently? ☐ YES ☐ NO

5. In the last five years, have you been diagnosed with or treated for a condition that significantly disturbs your cognition, behavior, or motor function, and that may impair your ability to practice as a dental hygienist safely and competently including but not limited to bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder? ☐ YES ☐ NO

6. Are there any other facts concerning your background history, experience, or activities which may have a bearing on your fitness to practice dental hygiene in Colorado and which should be brought to the attention of the Colorado Dental Board? ☐ YES ☐ NO

ATTESTATION

I hereby certify that I have met ALL the requirements for administration of local anesthesia or a local anesthesia reversal agent in the state of Colorado as provided for in Colorado Revised Statutes section 12-35-107(1)(f) and Board Rule XIV.

Further, I attest that I shall remain in compliance during all periods of time that I administer local anesthesia or a local anesthesia reversal agent.

I state under penalty of perjury in the second degree, as defined in C.R.S. 18-8-503 that the information contained in this application is true and correct to the best of my knowledge. In accordance with C.R.S. 18-8-501(2)(a)(I), false statements made herein are punishable by law and may constitute violation of the practice act.

_____ _____

Applicant Signature Date

COMPLETION OF TRAINING VERIFICATION
LOCAL ANESTHESIA

Applicant Name: Last:	First:	Middle:	Suffix:
Telephone Number: ( )			
School Name:	**Date of training completion:**		

The above-named person, who is applying for a privilege to administer local anesthesia as a Dental Hygienist, has met the requirements by completing the following courses:

- **Twelve (12) hours of didactic training**, including, but not limited to:
  - Anatomy;
  - Pharmacology;
  - Techniques;
  - Physiology; and
  - Medical Emergencies.

—AND—

- **Twelve (12) hours of clinical training** that includes the administration of at least six (6) infiltration and six (6) block injections.

I hereby declare under penalty of perjury under the laws of the state of Colorado that the above statements are true and correct.

_____ _____

Signature of Registrar/Director Date